

HYPERTENSION DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT: The Department of Veterans Affairs (VA) *will not pay or reimburse* any expenses or cost incurred in the process of completing and/or submitting this form. Please read the privacy act and respondent burden information on reverse before completing form.

NAME OF PATIENT/VETERAN:	SSN:	EXAMINATION DATE:
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NOTE TO PHYSICIAN: Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

ACCEPTABLE CLINICAL EVIDENCE (ACE) AND EVIDENCE REVIEW

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

- Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the DBQ and such an examination will likely provide no additional relevant evidence.
- Review of available records in conjunction with a telephone interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with a telephone interview provided sufficient information on which to prepare the DBQ and such an examination would likely provide no additional relevant evidence.
- Examination via approved video telehealth
- In-person examination

EVIDENCE REVIEW

EVIDENCE REVIEWED (*check all that apply*):

- Not requested
- VA claims file (hard copy paper C-file)
- VA e-folder (VBMS or Virtual VA)
- CPRS
- Other (please identify other evidence reviewed):
- No records were reviewed

EVIDENCE COMMENTS:

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SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION BASED ON THE FOLLOWING CRITERIA?

NOTE 1: For VA disability rating purposes, the term hypertension means that the diastolic blood pressure is predominantly 90mm or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm or greater with a diastolic blood pressure of less than 90mm.

NOTE 2: For VA purposes, the INITIAL diagnosis of hypertension or isolated systolic hypertension must be confirmed by readings taken 2 or more times on at least 3 different days. Blood pressure results may be obtained from existing medical records or through scheduled visits for blood pressure measurements.

<input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "YES," provide only diagnoses that pertain to hypertension):</i>	ICD Code:	Date of Diagnosis:
<input type="checkbox"/> Hypertension		
<input type="checkbox"/> Isolated systolic hypertension		
<input type="checkbox"/> Other, specify: Other Diagnosis #1		
Other Diagnosis #2		

1B. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION, LIST USING ABOVE FORMAT:

NOTE 3: ALSO complete appropriate questionnaires for hypertension-related complications, if any (such as VA Form 21-0960J-1, Kidney Conditions (Nephrology) Disability Benefits Questionnaire, if renal insufficiency is attributable to hypertension.)

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S HYPERTENSION CONDITION *(brief summary)*:

Approximate date of diagnosis:

Date when medication first started:

Course:

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION?

YES NO *(If "YES," list only those medications used for the diagnosed conditions):*

2C. WAS THE VETERAN'S INITIAL DIAGNOSIS OF HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION CONFIRMED BY BLOOD PRESSURE READINGS TAKEN 2 OR MORE TIMES ON AT LEAST 3 DIFFERENT DAYS?

YES NO UNKNOWN *(If "YES," provide BP readings used to establish initial diagnosis, if known):*
(If "NO," report BP readings taken 2 or more times on at least 3 different days in order to confirm diagnosis (unless Veteran is on treatment for hypertension.))

READING # 1: /	READING # 2: /	DATE OF READING:
READING # 1: /	READING # 2: /	DATE OF READING:
READING # 1: /	READING # 2: /	DATE OF READING:

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2D. DOES THE VETERAN HAVE A HISTORY OF A DIASTOLIC BP ELEVATION TO PREDOMINANTLY 100 OR MORE?

YES NO (If "YES," describe frequency and severity of diastolic BP elevation):

SECTION III CURRENT BLOOD PRESSURE READINGS (SUFFICIENT IF VETERAN HAS A PREVIOUSLY ESTABLISHED DIAGNOSIS OF HYPERTENSION.)

READING # 1: /	DATE OF READING:
READING # 2: /	DATE OF READING:
READING # 3: /	DATE OF READING:
AVERAGE BLOOD PRESSURE READING:	

SECTION IV - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

4A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITION(S) LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES NO

IF "YES," DESCRIBE (brief summary):

4B. DOES THE VETERAN HAVE ANY SCARS (SURGICAL OR OTHERWISE) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES NO

IF YES, ARE ANY OF THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM (6 square inches); OR ARE LOCATED ON THE HEAD, FACE OR NECK? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

YES NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

Location: _____ Measurements: length _____ cm X width _____ cm.

NOTE: If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

4C. COMMENTS, IF ANY:

SECTION V - FUNCTIONAL IMPACT

5. DOES THE VETERAN'S HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION IMPACT HIS OR HER ABILITY TO WORK?

YES NO (If "YES," describe the impact of the Veteran's hypertension or isolated systolic hypertension, providing one or more examples):

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SECTION VI - REMARKS

6. REMARKS (if any)

Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION VII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

CERTIFICATION: To the best of my knowledge, the information contained herein is accurate, complete and current.

7A. PHYSICIAN'S SIGNATURE	7B. PHYSICIAN'S PRINTED NAME	7C. DATE SIGNED
7D. PHYSICIAN'S PHONE AND FAX NUMBER	7E. PHYSICIAN'S MEDICAL LICENSE NUMBER Lic: #	7F. PHYSICIAN'S ADDRESS

NOTE: VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the Veteran's application. If questions or issues arise upon review of this Examination, please contact the VA Medical Center or DOD facility that processed the request for examination.
Contractor: Logistics Health Incorporated

Privacy Act Notice: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

Respondent Burden: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.